AUTHORIZATION TO RELEASE MEDICAL RECORDS

Capstone Family Practice
6401 Cypresswood Drive- Suite 180, Spring, TX 77379
Phone: (281)866-7080 Fax (281)866-7151

Patient Name:_____

Date of Birth: _____ SS#: _____

I authorize Capstone Family Practice to release confidential medical records to:

Doctor's Name: _____

Address:_____

City:_____State:_____ Zip:_____

Phone: _____ Fax: _____

Purpose:

☐ SSI/Disability
☐ Nursing Home Placement
☐ Legal/Attorney
☐ Continuation of Care
☐ Other (please specify): _____

The following will be sent:

☐ Entire record
☐ Diagnostic test results
☐ History and physical exam
☐ Consultation report
☐ Other (please specify): _____

Notice to Patient: Pursuant to state and federal law, you are hereby advised that the information that you authorize for release may include any/all results, diagnosis, and/or treatment for HIV, STD's, psychiatric disorders, or drug and alcohol abuse.

I understand that I may revoke this authorization in writing at any time prior to the release of information specified above. I hold harmless Andy Spafford, MD and Tina Corkran, MD and/or his/her representatives from liability resulting from the release of the above information. This authorization expires 90 days from the date signed.

_____ OR _____ _____
Signature of Patient Signature of Guardian Date

Notice to recipients of information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42, CFR Part 2) prohibit Capstone Family Practice from making any further disclosures without written consent.